

THE D E N T A L *Digest*

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EDWARD J. RYAN, B.S., D.D.S., Editor

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708 Church Street, Evanston, Illinois

ROY MCCLURE PATTERSON, D.D.S. was graduated from the Baltimore College of Dental Surgery, Dental School, University of Maryland in 1907. Doctor Patterson who has previously contributed to the professional literature maintains a general dental practice, and his article in this issue is one that all general practitioners will be able to transfer immediately into their practices.

S. JOSEPH BREGSTEIN, D.D.S. (New York College of Dentistry, 1921) has been a consistent writer for many years on the subjects of economics and dental caries in particular. He is the author of the following books: "Business Conduct of an Ethical Practice"; "The Dentist and His Control of Practice"; "Preparation Manual for Accident Cases." Doctor Bregstein formerly taught operative dentistry at the New York College of

About our **CONTRIBUTORS**

Dentistry and is now on the postgraduate teaching staff of the Allied Dental Council. PROPHYLACTIC CARIES CONTROL is likewise a practical innovation which other general practitioners may try at once.

ROWE SMITH, D.D.S. (Vanderbilt University, 1923) has a postgraduate certificate from Northwestern University Dental School (1928) and another from the University of Vienna (1937). Doctor Smith has contributed numerous other articles to the periodical literature, chiefly on anesthesia and periodontia, and his practice emphasizes periodontia and oral diagnosis.

P. PHILIP GROSS received his D.D.S. degree in 1922 at the University of Pennsylvania. He has previously contributed to this magazine articles on ALVEOLECTOMY AND IMMEDIATE DENTURE INSERTION (October, 1938) and a TECHNIQUE FOR APICOECTOMY (March, 1939). Doctor Gross is on the staff of the American Oncologic Hospital where he likewise gives postgraduate instruction in exodontia, anesthesia and oral surgery.

SAMUEL CARTIN received his D.D.S. at the Ohio State University College of Dentistry in 1934. Doctor Cartin is the author of numerous articles on exodontia and particularly anesthesia and has collaborated with Doctor M. Hillel Feldman who has been a repeated contributor to this magazine and whose drill technique is described in Doctor Cartin's present article.

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Forty-Five Minute Permanent Rebase

R. McCLURE PATTERSON, D.D.S., Detroit

DIGEST

A rebasing technique is suggested with a two-fold function:

1. To provide an *immediate* rebase, so that the patient is not deprived of his *immediate* dentures at any time. This is not a makeshift but a finished service.

2. To reline old dentures when absorption has taken place—without a patched appearance.

AS FAR BACK AS the time when vulcanite was given to dentistry for the construction of dentures and students were taught to set up teeth on trial bases to conform to the circle of a silver dollar, dentists have had the problem of adjusting ill-fitting dentures. They have tried everything from remaking the denture to lining the denture with so-called semipermanent impression materials.

The last few years dentists have been providing patients with immediate dentures. A technique is suggested here for an immediate rebase—one that can be done while the patient waits, in the time of the average office appointment. The rebase to be described is an integral part of the denture. The advent of the acrylics has given dentists the means for producing this result and an easy forty-five minute technique for a finished rebase has been developed. This immediate denture rebase will carry patients over with comfort to the time of the second denture. It should be borne in mind that patients have been promised immediate dentures. They should not be disappointed by having to part with their denture for a day or two for rebasing.



Fig. 1—Maxillary denture washed with soap and warm water, dried, and again washed with chloroform or acetone.



Fig. 2—The paste being mixed in a clean porcelain jar with a stainless steel spatula.



Fig. 3—Paste being spread in the denture.

If it is found necessary to rebase permanent dentures, to correct articulation or the vertical dimension, this technique is equally valuable. In view of the fact that the rebasing material is the same as the original denture, it has several advantages, the most important of which is that it does not look like a patched or repaired denture. It absolutely matches and is a finished service which is practical, time-saving, and inexpensive.

Procedure

1. 11:00 A. M.: The patient is in the chair.

2. 11:02 A. M.: The denture is washed in warm water and soap and the palate cleaned with chloroform or acetone.

3. 11:05 A. M.: The rebasing material is composed of crystolex powder and liquid acrylic denture material, which has rapid setting time and for that reason is preferred in this technique. A variation from the manufacturer's proportions is made in order to obtain the proper consistency. A mixture is made of 7.5 cc. powder (two partial denture measuring cups full), either colored or clear, and 12 cc. of liquid in a clean porcelain jar, a stainless steel spatula being used. Mix for thirty seconds and immediately spread the thin paste in the denture.

4. Cover the paste in the denture with moist .001 inch cellophane. The cellophane should be large enough to cover the palate completely and extend over the buccal and labial portions and over the teeth.

5. Immediately carry to the mouth and seat. Check for articulation and vertical dimension.

6. Remove from the mouth and examine and if any corrections are needed, add more thin paste. When correct, the case is ready for flasking.

7. 11:10 A. M.: Flask in any type of flask in the following manner:

a. Assemble the flask with the top removed.

b. Make a mix of quick-setting plaster and flow into the denture; partly fill the flask.

c. Invert the denture and place down in the plaster in the flask, completely filling the flask; place the top in position.

d. As soon as the plaster has set,



Fig. 4—Paste covered with moist cellophane, .001 inch in thickness.



Fig. 5—Denture with paste and cellophane placed in the mouth and articulation checked.

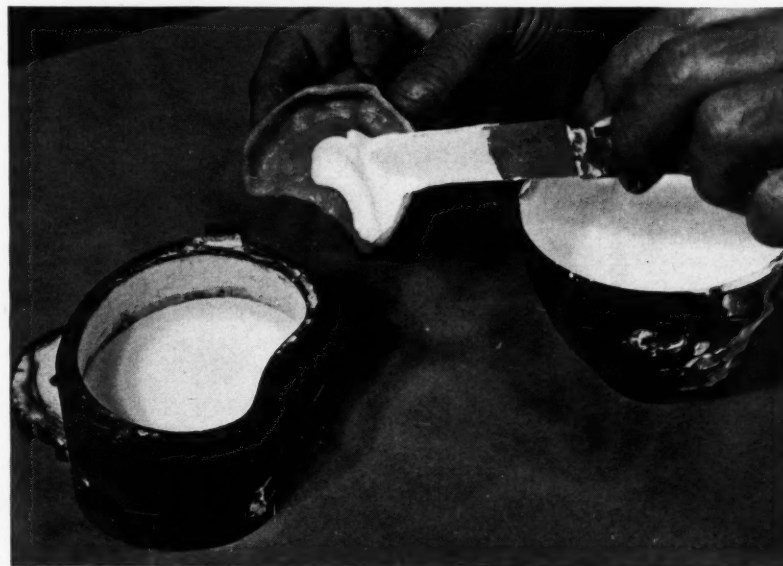


Fig. 6—Denture ready for flasking. (First fill the denture, then place in flask.)

Fig. 7—Flask filled with plaster ready for flask holder or bolts. When plaster has set, place in water and boil for thirty minutes.

place in boiling water for thirty minutes.

e. Remove and cool in running water and remove from the flask.

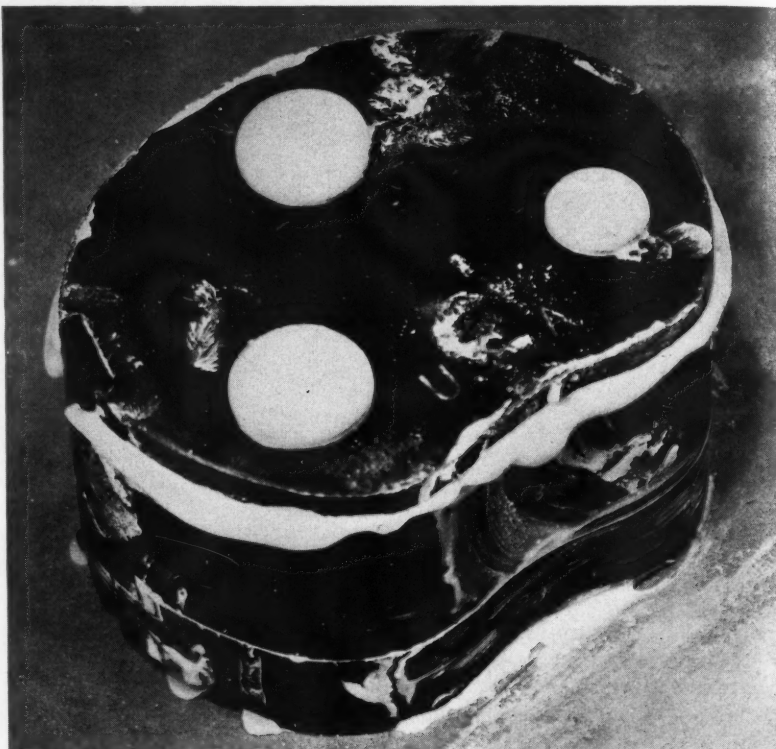
11:45 A. M.: Little if any finishing will be found necessary.

It will be found that the crystolex paste has united with the denture and has formed a finished reline.

Comment

Although this technique was originally developed for the relining of immediate dentures, it also has a place in the relining of old dentures when absorption has taken place, thus eliminating the necessity of the process known as "jumping dentures."

14800 Grand River Avenue.



Announcement of Books Received

THEORY AND PRACTICE OF CROWN AND BRIDGE PROSTHESIS (Illustrated), By Stanley D. Tylman, A.B., D.D.S., M.S., St. Louis, The C. V. Mosby Company, 1940.

COMPLETE DENTURES (Illustrated), By Merrill G. Swenson, D.D.S. and Vincent R. Trapozzano, D.D.S., St. Louis, The C. V. Mosby Company, 1940.

THE SCIENCE OF DENTAL MATERIALS, Second Edition Revised, By Eugene W. Skinner, Ph.D., Philadelphia, W. B. Saunders Company, 1940.

A RESEARCH CONFERENCE ON THE CAUSE AND PREVENTION OF DENTAL CARIES, Chicago, July, 1938, Sponsored By The Good Teeth Council for Children, Inc., Chicago, Just Published.

PHLEBITIS, By Otto Meyer, M.D., New York, Savoy Book Publishers, Inc., 1940.

Prophylactic Caries Control

S. JOSEPH BREGSTEIN, D.D.S., Brooklyn

PROPHYLACTIC ODONTOTOMY has been defined¹ as "the removal [of tooth structure] by cutting [away] of a defective part of a tooth in order that the area so treated may be protected from a threatened onset of caries. The operation is confined to those morphological imperfections called pits and fissures." These pits and fissures, or grooves are formed by an incompleteness of the developmental lobes of enamel. These fine hair-like openings cannot be kept free from debris by ordinary methods of mouth hygiene. Their diameters are less than that of the finest tooth-brush bristle. Bacteria lie within these openings and are protected from dilution or dislodgment by food and mucus above their nidus. Bacterial acids are formed and caries, it is believed, ensues from this source.

The treatment recommended by Doctor Thaddeus P. Hyatt is to excavate the pits and fissures. I believe that tooth structure can be conserved by eliminating this step.

Technique

1. Isolate the tooth with cotton rolls or rubber dam.
2. Saturate the occlusal fissures with fresh hydrogen dioxide, the oxygenation of which causes food particles to loosen.
3. A sharp, pointed explorer may be used to tease the hydrogen dioxide into the depths of the fissure.
3. Wash the debris with warm sprayed solution of any good mouth antiseptic. Repeat this process two or three times to obtain perfect cleansing.
4. Use a fine hoe excavator to get down as near to the bottom of the fissure as possible. This removes weak enamel rods and widens the area slightly.
5. Apply tincture of metaphen, full strength. To remove air bubbles, tease the chemical into position with Hyatt's prophylactic odontotomy instruments or a sharp pointed explorer. Allow the metaphen to remain for a few minutes.

DIGEST

In prophylactic caries control a modification of prophylactic odontotomy is suggested in which tooth structure is conserved. In this protective treatment of pits and fissures, operations are painless because the tooth is not excavated.

6. Wash the fissure again with hydrogen dioxide, then wash with sodium bicarbonate to neutralize acids. Flush and dry with alcohol.

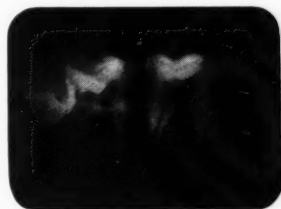


Fig. 1—Roentgenogram before treatment without drilling in the case of a boy aged 13.

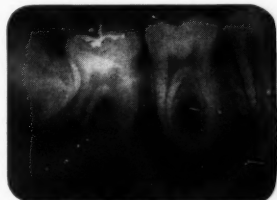


Fig. 2—Same case. Roentgenogram taken after treatment.

7. Apply ammoniated silver nitrate. Reduce with developing solution or oil of eugenol. Repeat this operation twice, then dry again with alcohol.

8. With the Hyatt instruments, pack soft amalgam into the fissure with a burnishing motion.

9. Add more amalgam and continue to burnish with a tiny ball-headed stellite instrument.

10. Wipe away all excess and remove packings.

Advantages

1. Operations are painless, thereby eliminating fear, especially in treating children.
2. Tooth structure is conserved.
3. Prophylactic caries control prevents future large cavities and pulp involvements.
4. Caries on the surfaces treated will be less likely to occur.
5. There is less danger of recurrent caries around large restorations.
6. Preventive dentistry is less costly than the fees for services involving large restorations.

Comments

Silver nitrate ought not be used on teeth anterior to the second bicuspid because of discoloration. When used on molars, however, the discoloration is rarely seen and in the method offered, the tooth is not changed in color so much as when silver nitrate is placed into a large cavity. When this agent is applied carefully to the fissures of a tooth, there is not much visible discoloration.

Some may feel that caries is incompletely removed from the depths of the fissures unless grinding is done. Silver nitrate² positively inhibits the growth of bacteria and is as fine a sterilizing drug as has been discovered.

The construction of an inlay or a good amalgam restoration for a tooth treated by prophylactic caries control may be postponed with safety indefinitely.

¹Hyatt, T. P.: Prophylactic Odontotomy, New York, The MacMillan Company, 1933, page IX.

²Prinz, Hermann: Diseases of the Soft Structures of the Teeth and Their Treatment, Philadelphia, Lea & Febiger, 1937, page 253.
454 Seventy-Fifth Street.

The Systemic Aspect of Periodontal Disease

ROWE SMITH, D.D.S., Texarkana, Arkansas-Texas

OBSERVATION AND clinical experience cause me to agree with those men who divide periodontal disturbances into two large groups: The first group, a disorder due to local irritation of the supporting tissues, has been termed Schmötz pyorrhea (Gottlieb-Orban classification) or paradentitis (Becks classification). The second group, which is usually characterized by extensive alveolar bone resorption, has been termed by Gottlieb and Orban diffuse atrophy, and by Becks paradentosis, and is probably a symptom of a general metabolic or systemic disturbance. This presentation will be chiefly concerned with the second group because of its probable systemic aspect.

Detailed medical examinations have been made and accurate records kept of a series of eighty-three cases in which a diagnosis of diffuse atrophy was made. The dental diagnoses were made from careful clinical and roentgenographic examinations, and models of the dentition in each case were made.

With a view toward stimulating further investigation, I would like to call attention to the common incidence of diffuse atrophy involving the supporting structures of the teeth of young persons. We ordinarily expect that tissue tolerance of the teeth and their supporting structures will diminish in the later years of life because metabolic changes are more likely to occur. It will be noted, however, that the cases in this series are of young persons. It seems significant that the lowered periodontal tissue tolerance began so early in life.

No attempt to draw any definite conclusions from these observations will be made; however, some observations may be of significance:

Medical examinations reveal that the most common abnormalities associated with diffuse atrophy are secondary anemia (hypochromic microcytic type) and a lack of normal thyroid function. Some of the patients, however, were normal in these respects. The chief complaints are extreme fatigue and nervousness, which are usually relieved following the

DIGEST

Attention is called to the high incidence of diffuse atrophy involving the supporting structures of the teeth of young persons, mostly young women, as revealed in a detailed study of eighty-three cases.

Thorough medical examinations disclosed the frequent association with diffuse atrophy of secondary anemia and lack of normal thyroid function. Generally, diffuse atrophy appears to be a disease of people otherwise well.

Local treatment seemed more effective than correction of nutritional deficiencies alone, although appropriate medical treatment reduced the treatment time and aided in maintaining control.

The routine physical examination and treatment employed are outlined in detail. A complete summary of the observations revealed by careful medical examination is reported and a summary of the general dental treatment is included.

The author urges the comparison of clinical observations with the data recorded in the literature with a view toward correlating conclusions concerning periodontal disease.

eradication of the inflammatory processes adjacent to the affected tooth, and appropriate medical treatment when indicated. Despite the presence of periodontal inflammation and extensive bone resorption, few suffered from any condition usually associated with focal infection. From the cases investigated, it seems usually to be a disease of well people. This appears contrary to reports of other investigators.

The bone resorption seems to be confined to the supporting structures of the teeth. The medical examinations in many cases included roentgenograms of long bones and the skull. The roentgenograms, however, revealed no abnormality of the bone structure in these areas. (Further investigation is planned.)

If the average exposure or developing time is followed in these cases, the roentgenograms will be too dark for diagnostic purposes; they appear over-exposed or over-developed. In order to procure good roentgenograms, it has been necessary to cut down the average exposure time. This might indicate that we are dealing with a type of alveolar bone having less than normal density.

Almost 75 per cent of the cases of diffuse atrophy in this study were in young women.

Migration of the teeth is evident in more than 60 per cent of the cases.

Only 20 per cent of the patients showed any discernible or roentgenologic evidence of calculus formations on the root surfaces.

Many had a full complement of teeth, including the third molars.

Only two patients had Vincent's infection on presentation, and none gave a history of this disease.

None of the patients in this series had had bismuth or mercury therapy.

The condition seems to affect blonds and brunets alike, although some investigators believe that blonds are more susceptible than brunets.

There is a possibility that hereditary influences may be an important factor in many of these cases. Full-mouth roentgenograms of the parents of many of the young patients in the

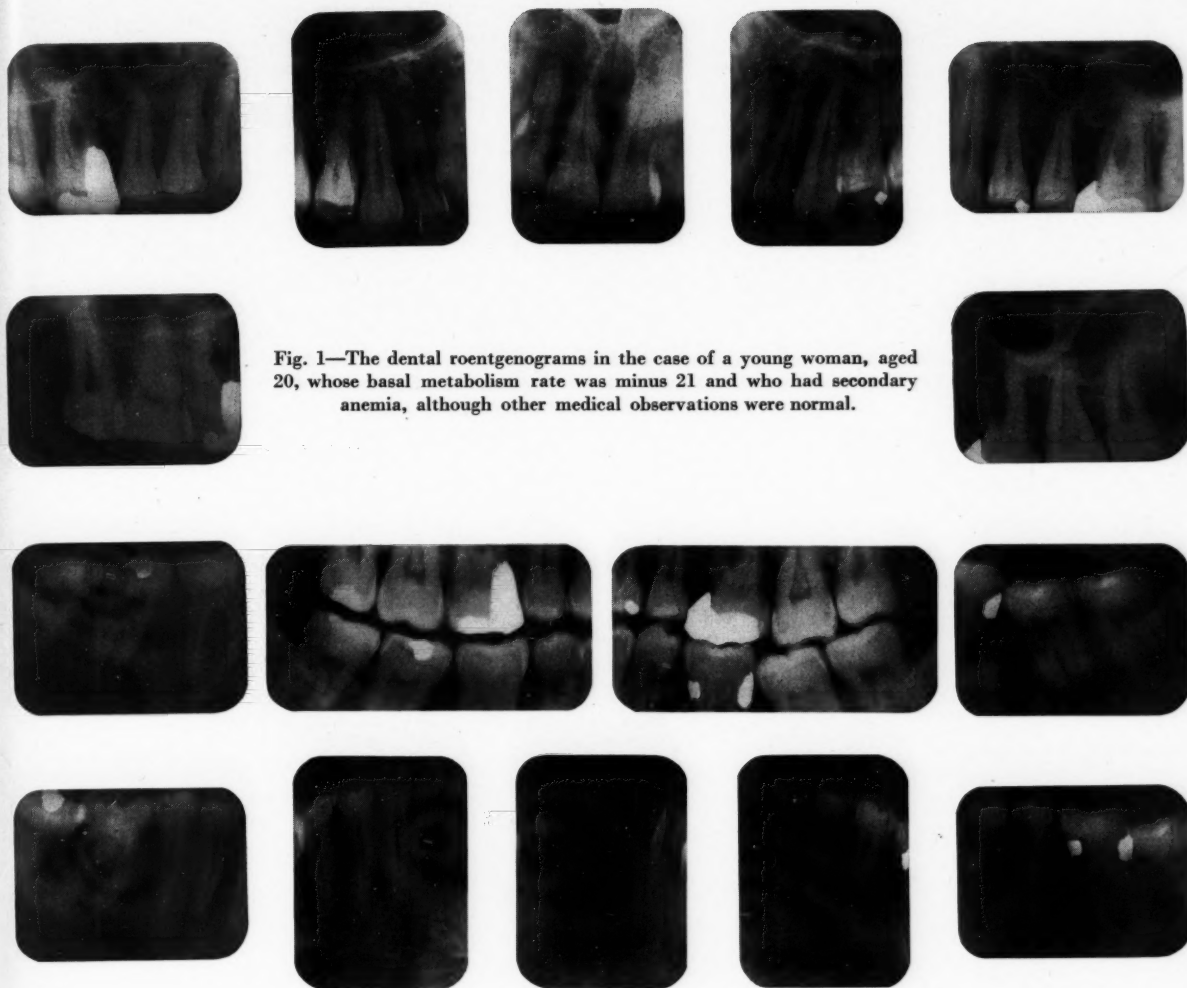


Fig. 1—The dental roentgenograms in the case of a young woman, aged 20, whose basal metabolism rate was minus 21 and who had secondary anemia, although other medical observations were normal.

series, show that the parents are affected; however, the disease occurred later in life and with less virulence. The dental history records that one or both parents lost all or most of their teeth as a result of so-called pyorrhea.

In this series there were three groups of sisters, all young, with the supporting structures of the teeth affected similarly, and two brother and sister groups.

None of the cases in the series showed any improvement clinically or roentgenographically following medical treatment and correction of possible nutritional deficiencies alone. Local periodontal treatment, together with restorative dentistry when indicated, proved to be the most effective control. Appropriate medical treatment and correction of possible nutritional deficiencies will apparently reduce the treatment time of these cases and will aid in the repair of the in-

jury done by the disease and in the maintenance of the established control.

It appears from clinical and roentgenographic observation that most of the cases in the series bear out Gottlieb's theory that the cementum that covers the root fails to form again normally on the affected tooth or teeth, and because of this condition of the cementum the affected tooth loses its normal degree of vitality. In other words, the tooth becomes sick; the alveolar bone loses its function and purpose, and, therefore, becomes resorbed. In this manner Nature attempts to exfoliate the tooth or teeth involved and is often successful, seemingly because of the abnormal condition of the cementum. It is possible that the loss of normal vitality of the cementum of the affected tooth may be influenced by the systemic dysfunctions.

Routine Physical Examination and Treatment

Each patient is given a complete physical examination and the medical history is taken, a particularly careful search being made for any foci of infection.

Laboratory investigations include: complete urinalysis; complete blood count; Kahn and Laughlen tests; blood calcium and blood sugar determinations; glucose tolerance test; gastric analysis; basal metabolism determinations; and roentgenographic examinations of long bones and skull. When indicated the blood urea determination, estimations of kidney functions, roentgenographic examination of doubtful organs, and electrocardiographic examinations are made.

When the history and clinical examinations indicate, instructions are given for correction of any probable dietary deficiency. In all such cases,

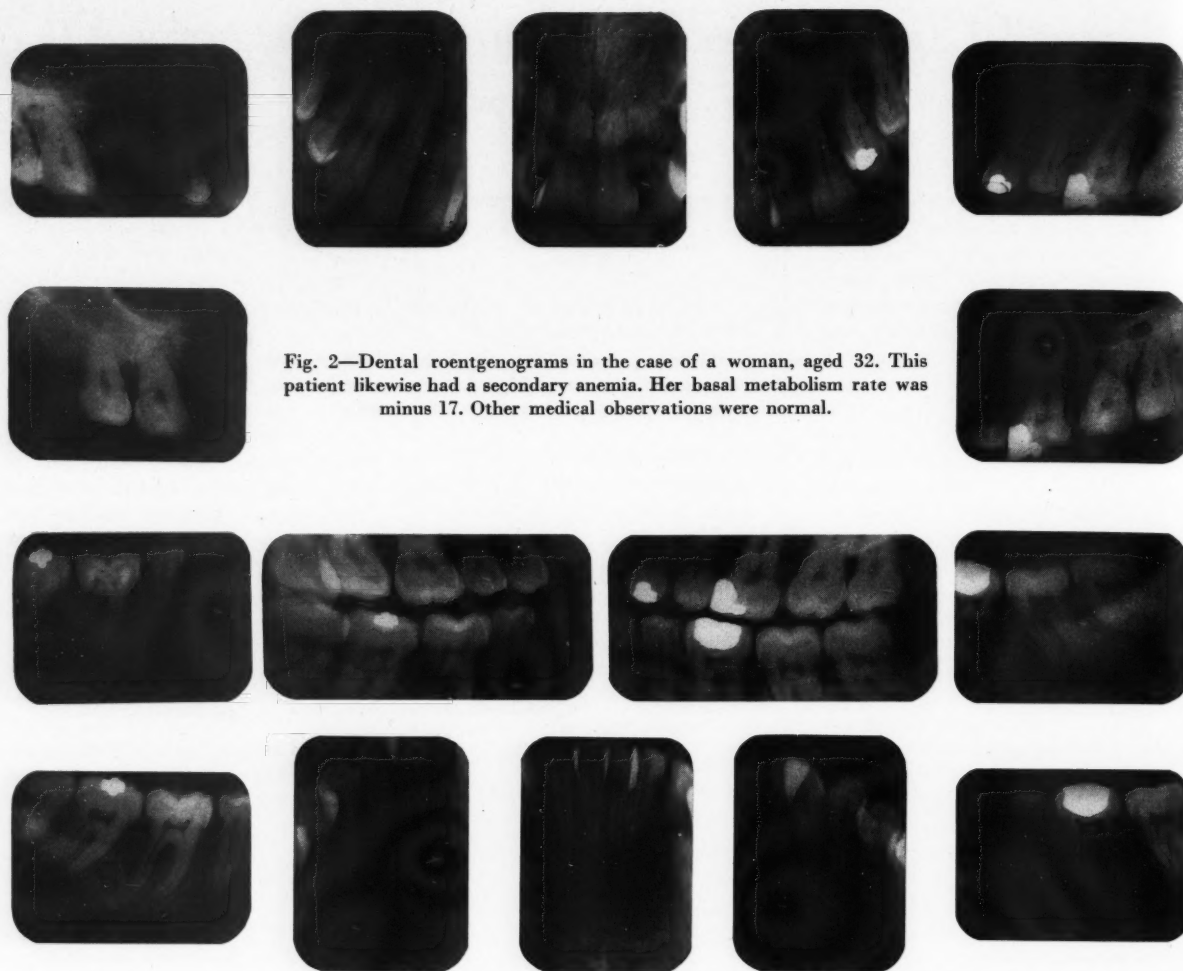


Fig. 2—Dental roentgenograms in the case of a woman, aged 32. This patient likewise had a secondary anemia. Her basal metabolism rate was minus 17. Other medical observations were normal.

attempts have been made to fortify the diet by the administration of concentrated vitamins, such as: A, B, C, D, and sometimes B₁.

When thyroid is indicated, the patient is usually started on two grains of desiccated thyroid daily and the dose is adjusted as suggested by clinical observation and determinations of the metabolism readings.

Virtually all the anemias associated with these cases have been of the hypochromic microcytic type (secondary anemia). Treatment has consisted of the administration of iron, either in the form of ferrous sulphate (30 grains daily) or ferrous carbonate (30 to 60 grains daily). These are given until the blood is normal, which usually takes two months.

Summary of Observations Revealed by Medical Examinations

Many of these examinations were checked by other recognized medical

clinics and the original essential data were verified.

1. The medical history shows that twenty-four of the eighty-three patients studied had suffered previous serious illnesses.

2. The laboratory examinations reported sixty with secondary anemia (hypochromic microcytic type).

3. Of this group fifty-one had an average minus basal metabolic rate, below normal, varying from minus 12 to minus 38. The average basal metabolic rate of seven was plus (two with a plus 4; one, plus 6; one, plus 8; one, plus 20; one, plus 34; one, plus 38).

4. Twenty-two were prematurely gray.

5. Thirty-nine were single.

6. Fourteen of the women were married and had children.

7. Only nine of the entire group were found to have any disease associated with focal infection.

8. None of these patients complained of chronic headaches or constipation.

9. None was abnormally overweight or showed extreme variations from normal stature and other measurements.

10. Despite the general systemic complaint of malaise or fatigue, and nervousness and the presence of advanced periodontal diseases, all these patients are ambulatory.

11. There was a wide variance in the occupations of the patients in this series.

12. Fifteen of the patients were from 14 to 20 years of age; twenty-seven were between 21 and 31; twenty-four were between 32 and 41; and seventeen were between 42 and 55.

13. Other diseases present at the time of initial examination included seven cases of rheumatism; two of pyelitis; one, albumin in the urine; two, acute Vincent's infection; four,

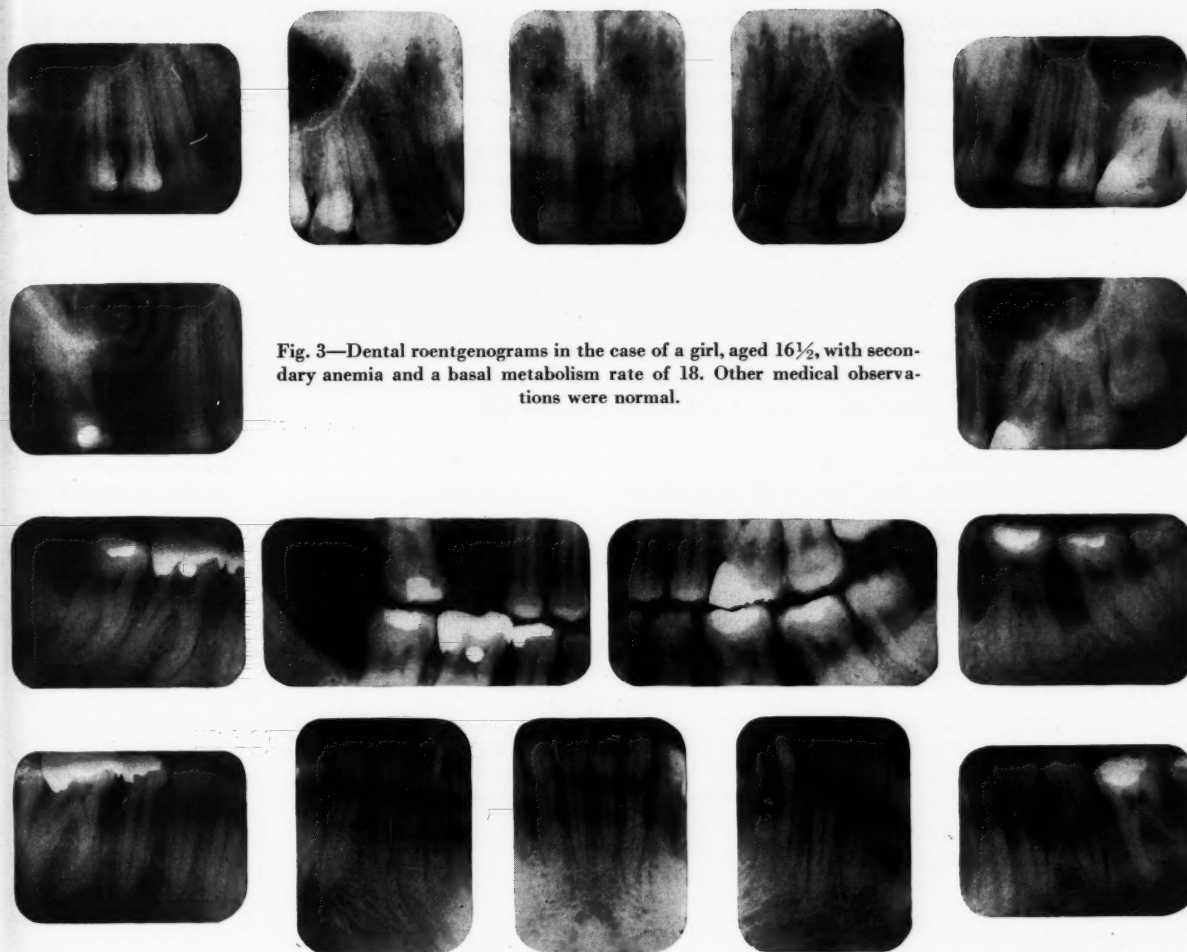


Fig. 3—Dental roentgenograms in the case of a girl, aged 16½, with secondary anemia and a basal metabolism rate of 18. Other medical observations were normal.

chronic tonsillitis; two, exophthalmic goiter; two, hypertension and cardiac disease; two, arthritis; one, external hemorrhoids; two, myxedema; one prostatic smear with pus cells; one partial facial paralysis (relieved after periodontal treatment); one fibroid tumor of the uterus; three, diabetes; one, exudative endometritis.

Summary of General Dental Treatment

Periodontal Treatment — Local symptoms (inflammation of the gum tissue and pocket formation) have been treated and eliminated as far as possible through prophylaxis, subgingival curettage, the Kirkland flap operation or Orban gingivectomy (as indicated).

Dental Treatment—Dental treatment consists of the following:

1. Removal of the calcareous deposits, if any, on the root surfaces of the teeth; relief of occlusal trauma, and maintenance of oral hygiene.

2. Removal of impacted, or partly impacted, third molars if there is any evidence of interference with the occlusion of the teeth, or if involved by infection.

3. Removal of teeth when the bone resorption has been so extensive that the teeth are left without sufficient bone to maintain them; removal of teeth, in most cases, when the periodontal infection and bone resorption involve either the bifurcation or trifurcation of multirooted teeth; and, usually, removal of teeth that cannot be made to function.

4. Restoration of the dentition to as near normal function as possible.

5. In some cases orthodontic treatment is utilized to move teeth that are in abnormal position to a near normal position. In none of the cases discussed here, however, was orthodontic treatment employed.

Comments

It appears impossible in many cases

to arrest completely the destruction of periodontal tissue once it has begun. Periodontal treatment, however, together with medical assistance when indicated, and institution and maintenance of oral hygiene, will usually control the bone resorption, delay the loss of the affected teeth, and usually prevent involvement of the supporting structures of the remaining unaffected teeth.

Everything possible should be done from a dental and medical standpoint for patients with periodontal conditions similar to the cases discussed here, because it is known that bone resorption can be controlled in many cases. Whereas extraction of the teeth will stop the inflammatory processes around the affected teeth, in many instances bone resorption continues even when all teeth are removed, perhaps because of the systemic background. As a result of continued resorption of the alveolar ridges, the denture bases must be changed at

regular intervals in order to maintain stability and a mild degree of comfort. Often, owing to continued resorption of the ridges over a period of years, there is nothing left on which to place a denture base. This means utter despair for the patient. For this reason, I would like to stress the necessity of attempting to save at least a few strategic teeth in each arch for anchorage for suitable restorations which may help or at least delay, this catastrophe.

It has occurred to me that the systemic background of patients who present with almost normal dentition and with no clinical or roentgenologic evidence of any dental disease should be carefully investigated, in order that the results of such investigations may be compared with the corresponding observations reported in the literature regarding patients with diffuse atrophy. If by such comparisons it should be found that approximately the same systemic background prevails for the two groups (those affected and those not affected by periodon-

tal disease), the deduction would be justified that the presence of systemic disturbances are merely coexistent and have no connection with diffuse atrophy, and that all periodontal disease probably is a local condition. On the other hand, should the correlations between the two groups reveal in the periodontal disease cases a low percentage of the observations usually associated with diffuse atrophy, it would indicate that there is a definite systemic aspect to some types of periodontal disease.

Once progressive alveolar bone resorption is established, it will continue until the causative factors are removed. In many of these cases the abnormal function of the thyroid gland may be an etiologic factor in the bone resorption. In those cases in which the basal metabolic determinations establish definitely the existence of a low thyroid function, the administration of thyroid extract will be necessary continuously for many years and possibly throughout life or until the basal metabolic determina-

tions are normal if the alveolar bone resorption is to be controlled. The periodic basal metabolic tests will determine the dosage and the necessity for the administration of thyroid extract. Often, as a result of life cycle changes, the action of the thyroid gland may return to normal. When alveolar bone resorption takes place early and remains active, it is necessary that a careful search be made for all etiologic factors so as to control or at least delay alveolar bone-wasting processes.

Alveolar diffuse atrophy is a problem awaiting intelligent solution. It is obvious that the medical and dental professions are in need of more knowledge as to its etiology, prognosis, and effect on the general health of those affected by this condition, and also as to the end-result if left uncontrolled by treatment. If there is a better understanding of the causative factor or factors, treatment is bound to be more effective.

405 East Fifth Street.

DENTAL MEETING

Dates

Ohio State Dental Society, seventy-fifth annual meeting, Netherland Plaza Hotel, Cincinnati, November 25-27.

Greater New York Meeting, Hotel Pennsylvania, New York City, December 2-6.

Pan American Odontological Association, fourth annual meeting, Wednesday evening, December 4, at Hotel Pennsylvania, New York City.

Dental Protective Association, annual meeting, Palmer House, Chicago, December 16.

The Greater Philadelphia Dental

Society, annual meeting, Benjamin Franklin Hotel, Philadelphia, February 4-7, 1941.

Chicago Dental Society, Midwinter meeting, Stevens Hotel, Chicago, February 17-20, 1941.

Alabama Dental Association, seventy-second annual meeting, Tutwiler Hotel, Birmingham, April 8-10.

Louisiana State Dental Society, sixty-first annual meeting, Hotel Roosevelt, New Orleans, May 1-3.

New Jersey State Dental Association, annual meeting, Berkeley-Carteret Hotel, Asbury Park, May 7-9.

Tennessee State Dental Association, seventy-fourth annual meeting, Hotel Andrew Johnson, Knoxville, May 12-15.

The Dental Society of the State of New York, annual meeting, Hotel Statler, Buffalo, May 13-16, 1941.

The Dental Society of the State of New York, annual meeting, Hotel Statler, Buffalo, May 13-16, 1941.

Georgia State Dental Association, seventy-third annual meeting, Hotel DeSoto, Savannah, May 19-21, 1941.

California State Board of Dental Examiners, next regular meeting, College of Physicians and Surgeons in San Francisco, week of December 16. Also at the University of California, College of Dentistry, during the same week. Applications must be filed at least 20 days prior to date of examination. For information write to Kenneth I. Nesbitt, D.D.S., 515 Van Ness Avenue, San Francisco.

New Jersey State Board of Dental Examiners, next regular meeting, week of December 9. Applications must be filed with the examination fee of \$25.00 with the secretary, Walter A. Wilson, D.D.S., 148 West State Street, Trenton.

The Editor's Page

AN EDITOR SHOULD make the attempt to visualize the readers of his publication as they live their lives. In the case of a professional, technical journal, it should be the editor's aim that that which is read may be translated into value in the reader's life. Articles that appear in this publication or any other should exhibit the usefulness and the range of service of the persons who read them. If articles are too complex, too esoteric, too detached from practical life; if these articles cannot, in the case of dental publications, be translated into practice and put to work for the dentist—then the articles are not good; they do not meet the test of practicality. An editor would like to think that every year each reader is able to get at least two or three ideas that he can put to work. If what is published in these pages improves the service that the dentist gives, if some of the tedium of practice is relieved, if the articles open new vistas for the dentist's professional imagination—then the magazine is fulfilling a function.

If it is true that the function of a publication, such as this, is to disseminate information to improve dental practice, so that the patient is better served and the dentist may increase his field of usefulness, it is proper to expect that from such an expanding experience the dentist may make a just and fair profit. How to put to work and into action new techniques, so that both parties in the transaction may profit is a matter that concerns every dentist. Two major obstacles to the expansion of dentistry to the desired degree are these: the unpleasantness of the experience and the lack of pride in possession. We cannot ever make the dental experience wholly painless and entirely pleasant. Even if no physical pain results the dental experience is so surrounded by suggestions of the unpleasant that we cannot hope to cut through existing preconceptions and banish them completely. Everyone would rather spend his time, his energies, and his money in search of the pleasurable ways of life than in pursuing the unpleasant, however necessary and beneficial. When it is said that people should prefer the dental experience to more pleasant engagements, a fundamental of human nature is forgotten. Dentistry cannot hope to compete with the dispensers of relaxation and amusement.

It is readily understood why healthy natural

teeth are sources of pride to people and why in direct proportion to the amount of dentistry done the pride of possession decreases. The patient feels no pride of possession in the acquisition of a dental restoration or a dental appliance. The person with full dentures or a removable bridge wishes to keep his secret if he can. Ornaments, new clothes, pretentious homes, automobiles are easily exhibited; they are possessions in which others may in a measure participate. They are seen by all who look and their notice is welcomed. On the other hand, that dental restoration on which the dentist works so assiduously is seen in its intimacy only by the dentist and less so by the patient. Whenever it is possible, the secret remains between them. The dentist's handicraft is known only to him. He has no overseer, no inspector checking to see if the caries has been removed from the tooth, if the margins of the restoration fit properly; he has only his conscience and his innate sense of workmanship to control him. The dentist's is a peculiar art. Only the charlatans who attempt to practice it exhibit their wares and proclaim their skills to the public. Ethical dentists do not engage in display.

The functioning of the dental mechanism is no aid to the expansion of a dental practice either. Physiology is a silent process. Parts that function in normalcy are silent, not felt, and are free from pain. Only when disease or disorder enters the picture do we feel the functioning of human parts. The dental mechanism unfortunately can function in great disharmony for years on end and still maintain its destructive silence. Pain does not come in warning and discomfort does not interfere until it is almost too late. This insidious habit of dental disease to remain silent makes people too slow to seek our services.

Dentistry's hope is in the expansion of individual practices by the dentist's own efforts to broaden his knowledge and his vision and to educate the patients at hand; to attempt to build up on another level another set of preferences based on the requirements and preservation of health and appearance—a set of preferences that will not be held in comparison or in competition with entertainment and possessions but will be regarded as an independent worth.

Treatment of Posterior Fragment in an Edentulous Fractured Mandible*

P. PHILIP GROSS, D.D.S., Philadelphia

FRACTURE OF THE mandible in the molar or the bicuspid region presenting a long edentulous movable fragment requires an appliance to keep that fragment from riding upward and inward and to stabilize the fragment until union takes place.

During the World War Bruhn and Lindemann¹ adapted a new principle—that of a nail extension into a hole in the fractured posterior fragment from which traction was obtained—either from a head cap or from an apparatus attached to the maxilla.

In the same period Faltin¹ drilled a hole in the fractured bone and fastened wires through the skin. These wires were used as traction in various directions depending on the angle desired.

In 1927 Lenormet and Darcissac¹ described a method of drilling a hole in each posterior fragment and passing a wire through the skin to the angle of each side of the mandible, connecting the wire ends by rubber elastics across the back of the neck. This was used for a bilateral fracture.

Also in 1927, Wassmund¹ placed wires through the angle of the mandible on the sound side and a nail extension through the angle of the affected side. A leather collar was placed across the back of the neck. This collar was connected to the wires on the sound side, and then by means of an elastic band to the nail extension on the affected side. An intermaxillary splint was placed on the teeth, to which was attached an extension bar to the outside on the fractured side. After traction from the rubber band had moved the fragment into position, the bar was slipped into the nail extension, thus holding the fragment in proper relationship. The collar was removed from the back of the neck.

In connection with these methods

DIGEST

Several methods for the stabilization of a movable fragment in the posterior region of an edentulous fractured mandible are reviewed.

The method of choice is an intermaxillary splint with an arm attachment. The construction of the appliance is described in detail.

Ivy² suggests the use of a hook attached to a plaster head cap. He then follows the method of Darcissac; drills a hole through the fractured fragment and passes a wire through the hole, coming through the skin to the angle. This wire is connected with elastics to the hook attached to the head cap.

Dorrance³ suggests the use of an arm attachment to the Dorrance-Howell Smith intermaxillary splint. The principle of the Dorrance-

¹Ivy, R. H. and Curtis, Lawrence: Fractures of the Jaws, Philadelphia, Lea & Febiger, 1931, pp. 78-81.

²Dorrance, G. M.: Personal communications to the author.

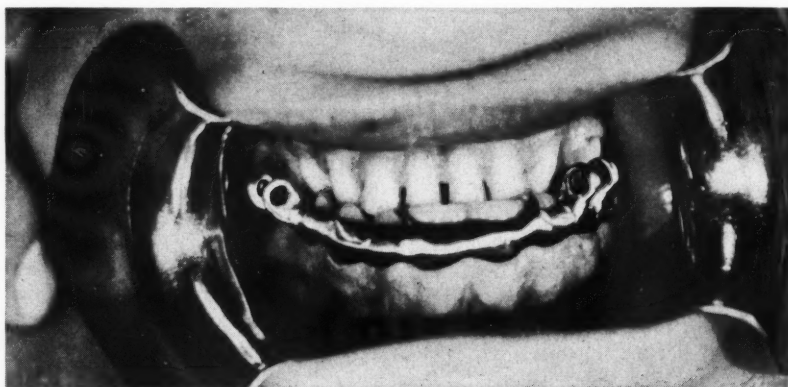


Fig. 1—Upper splint with lock attachments on each side. Teeth in proper occlusion.

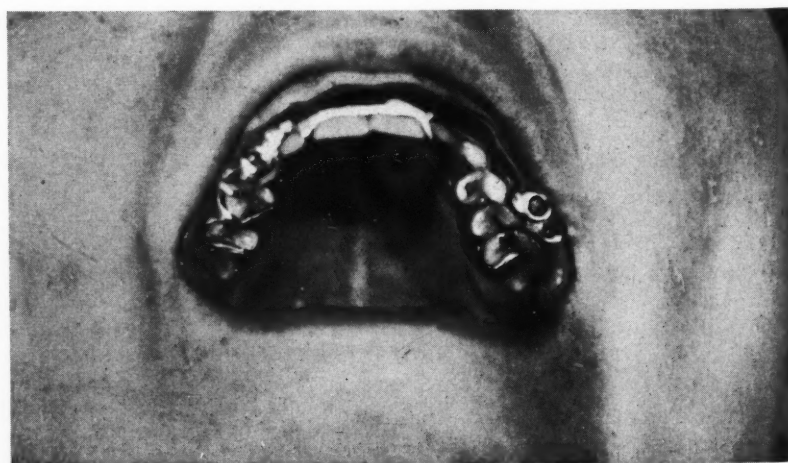


Fig. 2—Occlusal view.

*From the Department of Oral Surgery, American Oncologic Hospital, Philadelphia.

¹Dorrance, G. M. and Bransfield, J. W.: Historical Review of Treatment of Fractures of the Jaw, American Dental Association Exhibit, 1937 and 1938.

Howell Smith intermaxillary splint is to cover as much of the tooth as possible with metal without interfering with normal occlusion of the teeth. Locks are placed on each side of the splint with pins to allow opening and closing of the splint at any time. The splint used in this case is a modification of the principles described. The intermaxillary splint with the arm attachment is a simpler method than the application of a plaster head cap.

Construction of Splints

1. The splints are constructed of vitallium (chromium cobalt molybdenum) which is stronger and lighter than coin silver, used heretofore.

2. The arm attachment is welded to the splint on the side opposite the fracture.

3. The plate with the screw holes is welded to the arm attachment and the hook is made by bending the end of the arm attachment. The hook is used for traction to bring the fractured part into position; the plate is

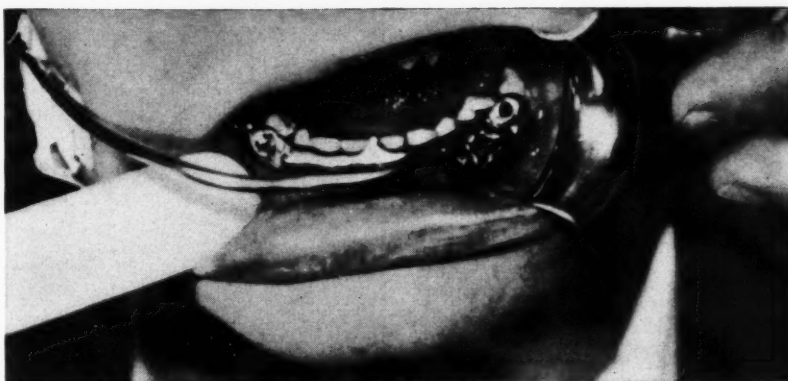


Fig. 3



Fig. 4

Fig. 3—Lower splint with lock attachments on each side. Extension arm from side opposite fracture.

Fig. 4—Splints closed in position; teeth in normal occlusion; locks in apposition.

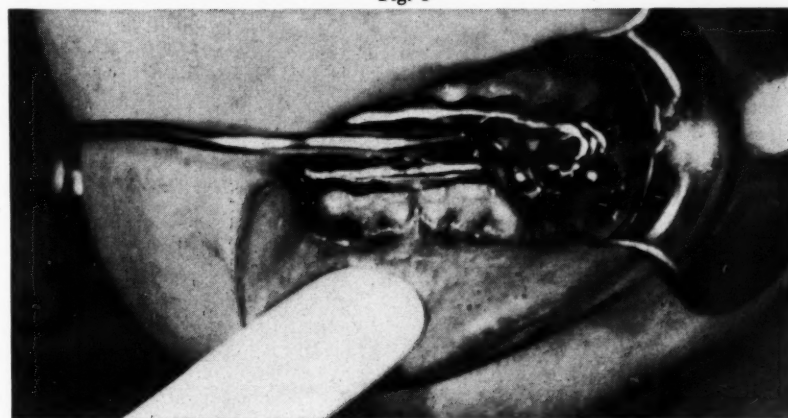


Fig. 5

Fig. 5—Pins in locks to keep upper and lower splints together may be removed at any time to open splints.

Fig. 6—Clearance of arm to prevent injury to mucosa.



Fig. 6

Fig. 7—Arm, with mouth closed.



Fig. 7

Fig. 8—Hook (a) to be used for elastic traction when it is necessary to place wires through skin and drill a hole through fractured bone fragment. Chromium cobalt molybdenum plate (b) for screw fixation when fragment is reduced to proper position.

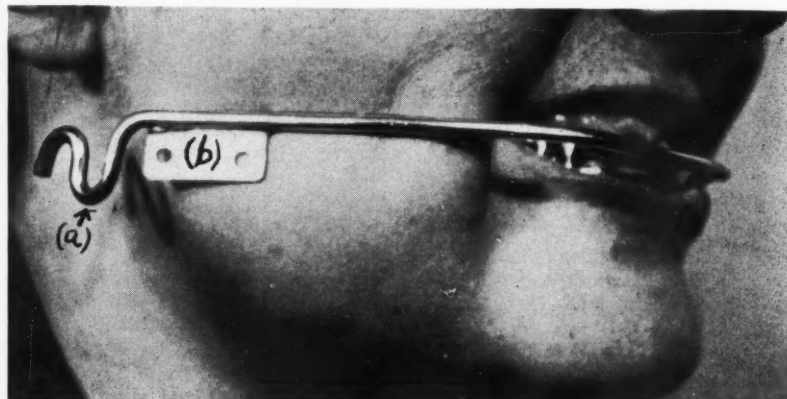


Fig. 8

Fig. 9—Screw with lock nuts on each side of plate to prevent loosening of screw.

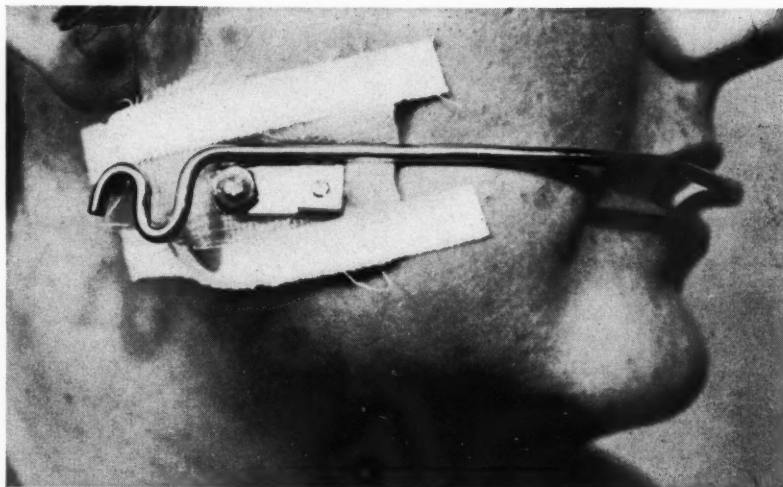


Fig. 9

used to hold the vitallium screw. The screw is passed through the skin into the bone to hold the fragment in position.

The arm attachment from the intermaxillary splint is comfortable to the patient and does not interfere with the movement of the lips.

This appliance can be used in cases of removal of large cysts in edentulous posterior areas to prevent pathologic fractures, and in cases in which a section of bone is to be removed. The posterior fragment is kept in position until regeneration of the bone takes place or a bone graft is inserted.

6740 Torresdale Avenue.

UNSOLICITED MANUSCRIPTS

FROM TIME to time THE DENTAL DIGEST receives inquiries regarding its attitude toward unsolicited manuscripts. These are especially welcome. There are many excellent dentists who have original suggestions, who have improved or modified a technique or have refined an operation; but these men do not contribute to the literature because they are afraid they do not know how to "write." Dentists are not expected to be "writers." If they will tell their story in a straightforward manner, the editors will be happy to cooperate with them in presenting their story. Unsolicited material that is sent to THE DENTAL DIGEST is read with care and open-mindedness and is reported on promptly.

Surgical Exodontia Without the Aid of Mallet and Chisel

SAMUEL CARTIN, D.D.S., Toledo, Ohio

DIGEST

The Feldman drill technique in exodontia is discussed:

1. A bi-beveled, spear-pointed drill is used in the dental handpiece to take the place of the mallet and chisel.

2. The advantage stressed is the elimination of trauma.

3. The technique is exemplified in its application to the removal of impactions, partial impactions, lower bicuspid roots, lower molar roots, and fractured roots.

4. The step-by-step technique is outlined.

THE PRINCIPLES of the Feldman drill technique as used in exodontia will be discussed here. Surgical burs have been used by many dentists, but Doctor M. Hillel Feldman of New York

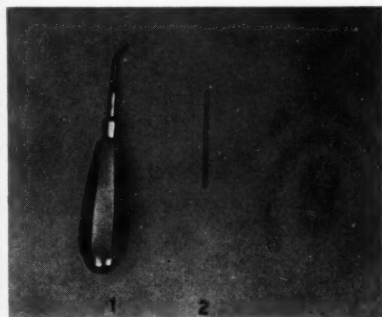


Fig. 1—Instruments used in removing roots and impacted teeth: (1) patholever and (2) drill.

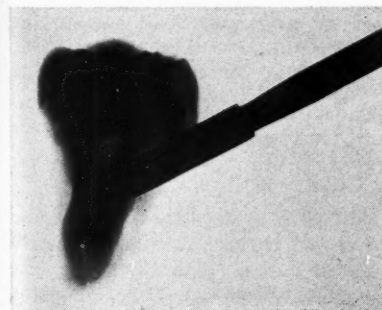


Fig. 2—Position of drill in root.

City has devised the instruments and developed the technique to be described in this article.

The drill is a bi-beveled, spear-pointed instrument which, when used in the dental handpiece, takes the place of the mallet and chisel. The drill will cut into bone or tooth structure, with the exception of enamel, without trauma, without clogging, and without over-heating or burnishing. The drill is quickly sharpened with a medium-fine sandpaper disc. It can be sterilized by autoclaving, boiling, or by the use of cold sterilizing solutions. Excessive pressure is not needed to make this instrument cut. The cutting efficiency depends on the tremendous speed of the dental engine.

Technique

1. A hole is first drilled into the root.

2. The Feldman patholever is wedged into the hole.

3. With a lifting force, the buccal wall of the alveolus being utilized as the fulcrum, the root is lifted from its bed in the alveolar process.

a. If the roots are diverged or exostosis is present, the roots are easily split apart with the drill and then removed separately.

b. Should the crown of a tooth be in a wedged position, a separation is made by drilling into the neck of the tooth in various directions.

c. The crown and roots are then removed separately.

Impactions—Impacted teeth or embedded roots can be drilled away with a minimum of postoperative complications, such as occur when a mallet and chisel are used for the purpose. In the removal of impactions (1) a minimum amount of bone is removed over the crown of the tooth; (2) then with a mounted stone, the enamel is pierced; (3) with a large round bur, the dentine is removed, the enamel being undermined; (4) the crown is then cracked off with an instrument; (5) the roots are removed in the usual drill technique manner.



Fig. 3—Tooth impinging upon the tip of the Feldman patholever.



Fig. 4A



Fig. 4B

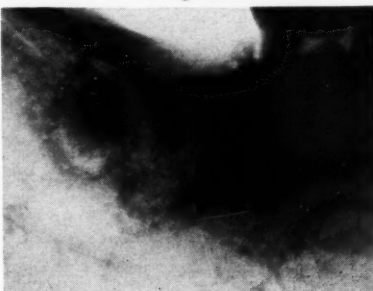


Fig. 4C

Fig. 4—Removal of a partly impacted lower third molar. A, Drill entering neck of tooth at a 45° angle; B, tooth being lifted out of its bed impinged upon patholever; C, postoperative appearance.



Fig. 5A



Fig. 5B



Fig. 5C

Fig. 5—Removal of a lower bicuspid root. A, Drill entering the root at an angle of 45 degrees; B, root being lifted out of its bed; C, postoperative appearance.

Removal of Partial Impactions—The removal of a lower partly impacted third molar illustrates the technique aptly. The principle is basic and is used in exactly the same manner in every condition. For the sake of clarity, variations will not be discussed.

1. A mesial flap is retracted to ex-

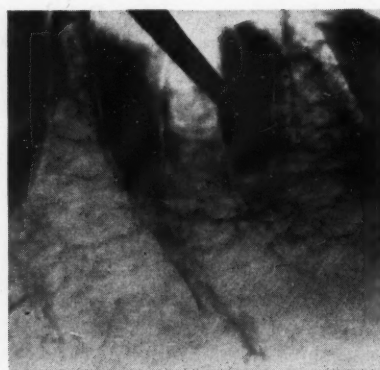


Fig. 6A

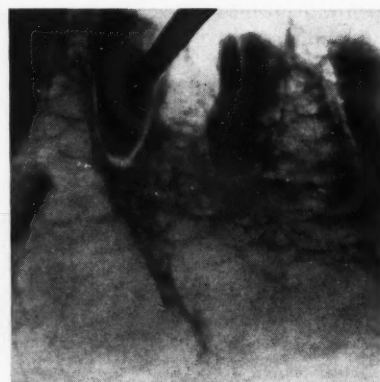


Fig. 6B



Fig. 6C

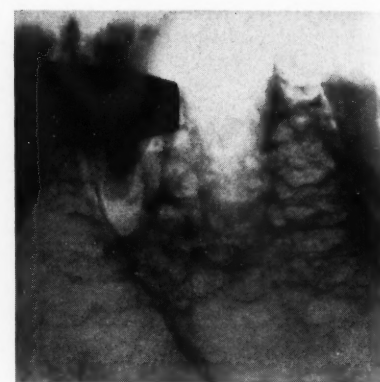


Fig. 6D



Fig. 6E

Fig. 6—Removal of lower molar roots. A, Drill in distal root at an angle of 45 degrees; B, drill in mesial root at an angle of 45 degrees; C, patholever inserted in distal root; D, patholever inserted in mesial root; E, postoperative appearance.

pose the mesio-buccal surface of the tooth.

2. The drill is placed against the mesio-buccal surface of the neck of the tooth at a forty-five degree angle.

3. In a few seconds, the rapidly spinning drill enters the neck of the tooth.

4. The patholever is wedged tightly into the hole.

5. With a lifting force and a twist of the wrist, the tooth is removed.

Removal of Lower Bicuspid Root—The removal of a lower bicuspid root, as illustrated here, is accomplished in essentially the same manner: (1) A mesial flap is retracted; (2) the drill is placed against the bone over the root at a forty-five degree angle; (3) after the hole has been made in the root, the patholever is wedged into the root and it is lifted out of its bed.

Removal of Lower Molar Roots—(1) Place the drill at the bifurcation aimed at the distal root at a forty-five degree angulation; (2) a hole is drilled into the distal root; (3) the drill is placed in the same position and allowed to enter the mesial root; (4) the patholever is wedged into the distal root; (5) the lifting force will usually remove both roots. Should

the mesial root remain, it is lifted out by inserting the patholever in the hole previously made.

Fractured Roots—Often roots are so fractured that their position can only be observed by means of a roentgenogram. In practice, when such a root is extracted, a rongeur is used to remove all the buccal plate up to the top of the fractured root. The drill is then allowed to enter the bone op-

posite the root at a point just below its fractured surface. The patholever is inserted into the hole and the root is lifted out.

Cleansing and Dressing of Alveolus

The cleansing and dressing of the alveolus is important. Splinters of bone are removed, and the edges are smoothed and rounded with one or more of the following: mastoid curet, rongeur, bone file, or mounted stone. When necessary, the flap is retained in position with sutures. A gauze matrix, impregnated with a vaselined mixture, is inserted in the socket for the topical prevention of pain. Such a matrix can often be used instead of sutures to retain the flap in position. The vaselined mixture consists of equal parts of thymol iodide, benzocaine, acetylsalicylic acid powder, incorporated in vaseline.

Comments

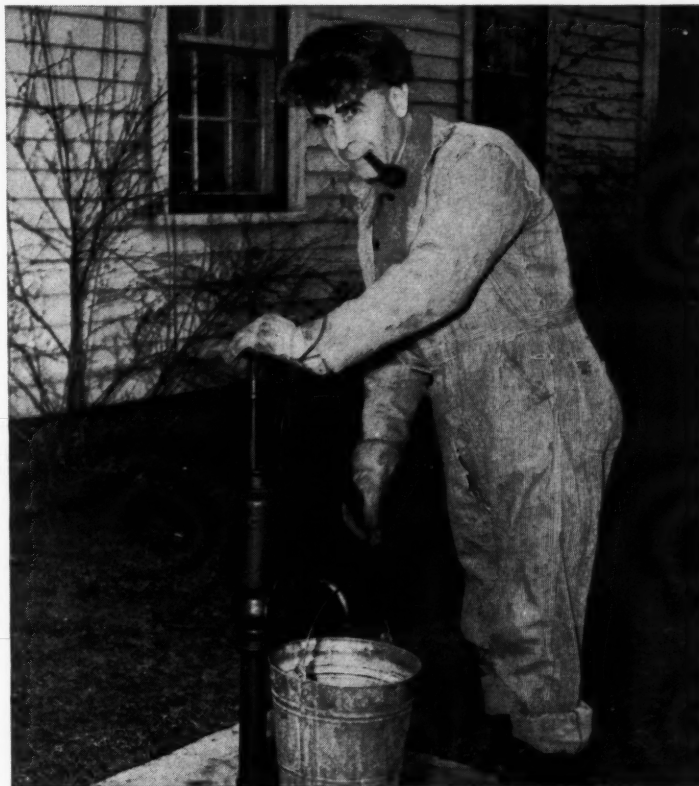
Although this technique may appear unusual, it is simple in principle, and is easy to manage. A Feldman drill and a Feldman patholever are all that are needed to complete the armamentarium. It is well to use this technique at first on an easy, partly impacted lower third molar. A broken lower cuspid or bicuspid root is another favorable tooth with which to start. The steps of the technique should be borne in mind and performed slowly and carefully.

Summary of Technique

1. Make the mesial incision for the flap through the soft tissue to the bone, with a Bard-Parker knife.
2. Retract the flap with a periosteal elevator.
3. Place the drill at the proper angulation against the root, and then set it in motion while holding it in position. The hole will be drilled in a fraction of a minute.
4. Place the patholever in the hole, and wedge it firmly into position; then lift out the tooth or the root as already described.
5. Complete the cleansing and dressing of the alveolus, being certain that all ragged bony edges are removed or smoothed.
6. Replace the flap and maintain it in position with sutures or with a vaselined gauze matrix.

Toledo Medical Building.

In your ORAL HYGIENE this month



(Photograph by Lou Moore, Erie, Pennsylvania.)

Can he practice successfully, back on the farm?

Your November ORAL HYGIENE has the answers to these provocative questions:

Is dentistry doing its part in the defense program? (p. 1347)

Are women welcome in dentistry? (p. 1356)

How can we be good neighbors to brother dentists in Central America? (p. 1361)

Can a city dentist practice successfully, back on the farm? (p. 1368)

Should you charge for examination and treatment? (p. 1370)

What did the daily papers tell about six different dentists? (p. 1373)

Why may tomorrow be too late? (p. 1376)

What about pulp hyperemia, and flabby tissue, and fluorosis, and medicinal odors? (p. 1380)

P.S.—Don't miss the new "annex" to the "Ask ORAL HYGIENE" department, the refresher course in picture-writing, "Technique of the Month."

In your November ORAL HYGIENE

BEFORE and AFTER



STEELE'S TRUPONTICS IN THE MOUTH OF YOUR PATIENT SPEAK FOR THEMSELVES.

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Remedy: The firemen and policemen of a New Jersey city have on sale to the public their own cough remedy, advertised in their fire houses and police stations.

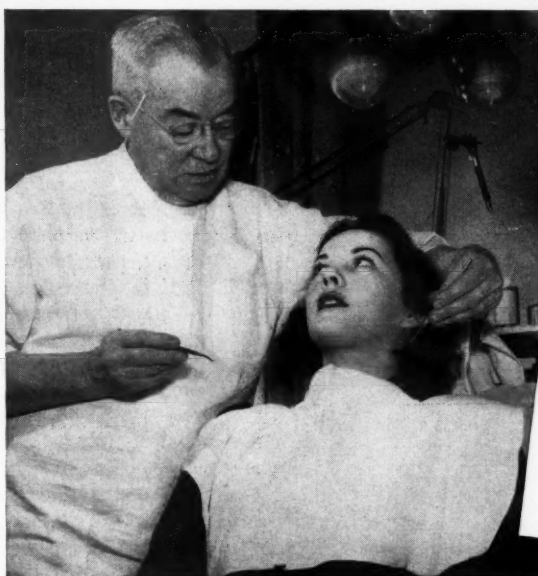
Speaking: Before the Essex County Dental Society in Newark where the Dental Society and every member of the society is a member also of the Academy of Medicine which is a splendid organization to increase the cordiality between dentistry and medicine.

Candor: An honest merchant carries this sign in his window: "Good Merchandise—Lousy Service."

Feet: A sign in a New Jersey city advises that now foot doctors have become "Surgeon Chiropodists."

Advertising: An advertising dentist announces in a Philadelphia paper: "Extractions Asleep or Awake."

Food: In this land of plenty more good food can be ruined by careless cooks than in any country in the world. There was once a country named France where the cooks could make the worse food taste delectable. The ruinous cooks of this country are not confined to the hamburger joints. Some of the swankiest hotels pour cold coffee and warm orange juice in front of breakfast faces and charge a dollar for the same order that would cost a quarter elsewhere and taste better. The difference is paid for the awesome armamentarium and the



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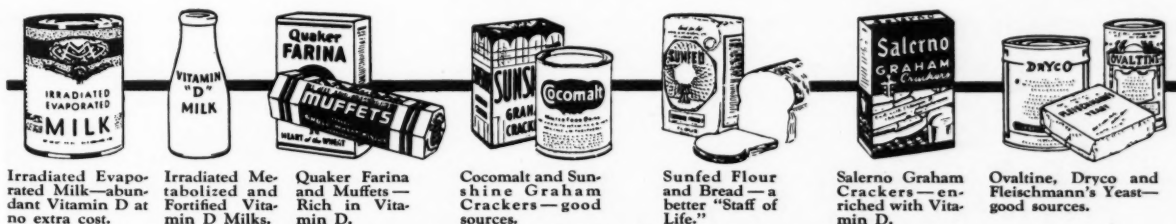
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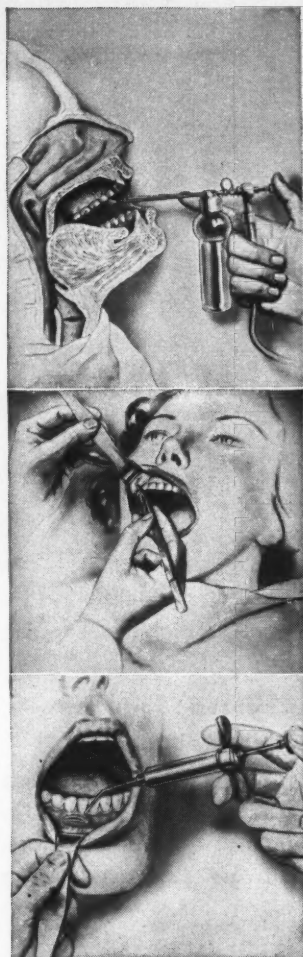
Cocomalt and Sunshin Graham Crackers—good sources.

Sunfed Flour and Bread—a better "Staff of Life."

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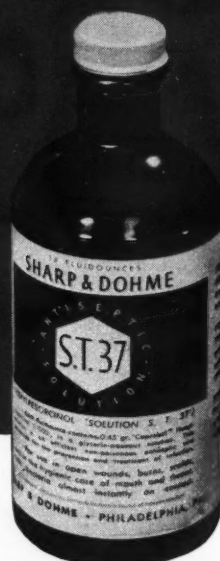
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Roads: Often the more populous the states, the poorer the roads. Ohio, for example.

Hague: All I have read in the papers regarding the Mayor of Jersey City has been unfavorable. He has been called a "little Hitler" and worse, if there is anything worse; but no one has done much to publicize the magnificent medical center he created for the care of the indigent in his city. It is unlikely that there is a finer medical center in the world than that in Jersey City. The dental department over which Frank J. Houghton presides does a marvelous job for the indigent children and adults in the community.

Opportunity: Walking down the street of Newark is a noseless man with a horrible makeshift appliance of some sort worn on his face to cover the missing part. Here is an opportunity for some dentist to use his prosthetic skill to reproduce a nose and perhaps return this man to society. Would it be ethical to stop this man and tell him of such an opportunity or must we lean backward in our ethics and hope that some day, some place, this person can find for himself someone to give him help. With these musings and this vacillating, I let the man pass from my sight, thus losing an opportunity to do some good.


War: All along the eastern seaboard are the feverish signs of war activity: the building of camps, the moving of army trucks, the displays of uniforms in the windows of men's shops, and everywhere the question: "Was your number called?"

Postman's Holiday: At the press conference of the *New York Herald Tribune*, in quick terse terms, a woman's page editor gives the ABC's of journalism:

A is for accuracy in every detail.

B is for brevity which is the essential of good writing.

C is for clarity which includes the newspaper quintuplets of the little W's: Who, Where, When, What and Why. Good writing whether it is in a dental publication or elsewhere is to eliminate, evaporate, dehydrate and deflate. The story of Genesis is told in 600 words. Lincoln did a splendid job with the Gettysburg Address with 266 words, and only 188 words were



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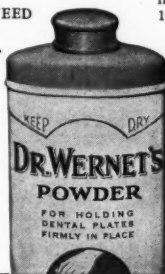
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consumed in the writing of the Twenty-Third Psalm.

Disillusionment: In Boston I learned that the Battle of Bunker Hill was fought on Breed's Hill; that Paul Revere never did get to Concord on that April night; that Mr. Longfellow's "one if by land and two if by sea" meant the Charles River because the sea is eight miles away. With the modern Paul Revere of Boston, Frank Rounds, the eminent oral surgeon, we rode over the course made famous by another dentist, Mr. Paul Revere.

Inferiority: To feel humble and inferior you should visit the New York Museum of Science and Industry and take a look at the Leonardo da Vinci exhibit. How one man in one life time could be one of the top-flight painters and sculptors of all time; an eminent architect, an authority on armaments, a mechanic and inventor of the first rank is indeed a wonder of the world. In the gallery where da Vinci's skills are shown is this quotation: "It is wrong to praise and worse to criticize a thing not understood."

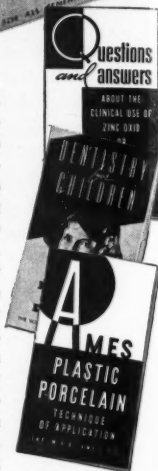
World's Fair: On the hands of the clock there were five days left to the New York's World's Fair. Again like the postman, we head straight for the health exhibits and once again it is proved that people like to fool with gadgets and to do things and to be entertained along with the educational process. At the health exhibits people blew into tubes to test their respiratory capacities; they weighed and measured themselves on tricky apparatus and observed the step-by-step procedures in human gestation. These were the exhibits that received the greatest attention.

In the future, in planning dental exhibits for the public, we should keep this in mind and not fill exhibits with historic museum pieces, such as antiquated instruments and lifeless figures. Exhibits must be in motion, in color, and preferably of a kind that people can operate themselves and thus test their skills and capacities.

Dental Foundation: The Massachusetts Dental Foundation under the vigorous leadership of John W. Cooke has now announced a bank dental plan serviced by the National Shawmut Bank of Boston. Under this plan patients may go to a bank and secure loans to finance their dental accounts. Bank financing has been attempted before but usually on a purely private basis between the dentist, the patient



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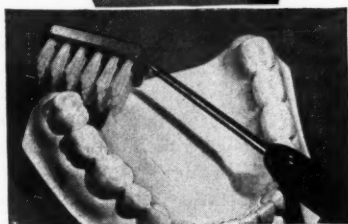
... you get them all with the SQUIBB *ANGLE* TOOTHBRUSH

WHEN you analyze the design of the Squibb Angle Toothbrush you will see that one of its unique features is the angle at which the brush head is bent. The brush is shaped like your dental mirror to make it easier to reach the less accessible places in the mouth.

Notice that the Squibb Angle Toothbrush has a thin but sturdy metal shank which makes it possible to bring the brush head down to the gum line while keeping the handle in a practically horizontal position. This facilitates cleaning between the teeth.

Look at the brush head. It's the small professional type. There are three rows of high quality natural bristles—six tufts to a row. Two degrees of stiffness—hard and medium.

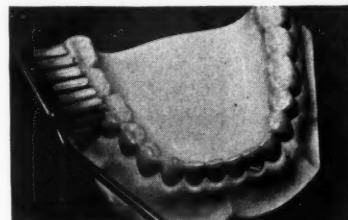
These features make the Squibb Angle Toothbrush really efficient. It is a brush that is suited to mouths of all types and adaptable to all brushing techniques—one that you will like to use yourself and be pleased to recommend to your patients.



The "Mouth-Mirror" angle makes it easy to reach behind the back molars.



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and the bank. This sponsorship of credit buying by a dental society has great national opportunities and is something that may well be investigated by every dental society.

Education: In New Hampshire a new school house carries this inscription: "What sculpture is to a block of marble, education is to the human mind." No matter how backward a community may appear, how paintless the houses, how bad the roads, how noisome the tenements—one building in every American community is likely to stand out new and clean and proud: There are more beautiful new schools in the United States than any other kind of public building. All the money spent in public improvement in the last few years has not been wasted.

Offices: A dentist need not be a big name, a big figure in a dental society or practice in a large town to be up to the minute and have a fine dental office. Visiting a dentist in a small New England village, I saw the latest in equipment and organization. Sometimes large city dentists look down their noses at their country cousins but the quality of dentistry produced has nothing whatever to do with the size of the town in which the practice is conducted, nor has the quality anything to do with the street address. The country doctor is obstetrician, surgeon and often the coroner. The country dentist must be everything himself: oral surgeon, prosthodontist, orthodontist—all rolled in one. He has no specialist to turn to for help or to share responsibility with him. His is a one man job and the job is often extremely well done. —E. J. R.

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